

St. Croix County Youth Community Support Services
(Targeted Case Management, Coordinated Family Services, and/or SED WAIVER)

*Please submit completed referrals to:
If internal DHHS referrals send to:
Tim Markgraf YCSS Unit
School referrals/other outside provider referrals send to:
Dawn Campbell- St. Croix County DHHS
(715) 246-8446*

Referral Form

Name of child (include middle initial): _____

Date of Birth: _____ **Age:** _____ **SSN:** _____

Funding source (circle): MA, SSI, Katie Beckett, Private Insurance, Parents, Other
(please describe) _____
MA #: _____

Please check all that apply:

- _____ Use of multiple direct services (e.g. mental health, special education, juvenile justice, child protective services, alcohol or other drug services)
- _____ Other interventions have not been successful over time, or persistent obstacles to service access and/or need for service coordination exists
- _____ At risk of out of home/institutional placement or transitioning back home from an out of home placement
- _____ Parents are willing to be involved in Youth Services

Child's Address: _____

Phone Number: _____

Living With: _____ **Relationship:** _____

Complete the following information if different from above:

Parent(s) Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____

List other significant people in the home (please include age and relationship): _____

List other significant people not in the home (please include age and relationship): _____

Referral Person: _____ **Phone Number:** _____ **Date:** _____

Reason for Referral: _____

Service Provider Information

Does the child have a Mental Health diagnosis?

Name of diagnosing Psychologist or Psychiatrist: _____

Contact information: _____

Mental Health Provider(s): _____

Contact Information: _____

Alcohol/Other Drug Abuse Provider(s): _____

Describe Involvement: _____

Is the child involved with the Juvenile Justice system, Child Protective Services (CPS)

If **yes**, please complete the provider information below and *attach documentation* of services (can obtain through the family's social worker).

If **no**, please continue with "Educational Provider" information.

Juvenile Justice, or CPS Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement:

Educational Provider: _____ **Special Education?** ___ Yes ___ No

Contact Person: _____ **Phone Number:** _____

Describe Involvement: _____

Other Agency/Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement: _____

Consent for Referral and Participation

I give my consent to _____ to refer my child and family members as identified to St. Croix County Youth Community Support Services. I agree to participate in the Youth Community Support Services process and to play an active role in the service deemed most beneficial to my child and family.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in St. Croix County Youth Community Support Services, it will be necessary for service providers to routinely review and share information.

_____ Date _____
Signature of Individual Authorizing Referral

_____ Date _____
Second Authorization/Witness Signature

St. Croix County Youth Community Support Services

**MULTI-AGENCY CONSENT AND AUTHORIZATION FOR
THE DISCLOSURE AND RELEASE OF CONFIDENTIAL INFORMATION**

I. Regarding the information and/or records of:	
Client/Student Name:	
Date of Birth:	
Address:	
Phone Number:	
II. Authorized Individuals/Agencies: (Please list all authorized individuals/schools/service agencies/law enforcement agencies/etc.)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
III. Authorization To Release: I authorize the above-named agencies/individual team members to disclose and release to each other the following information from my school/treatment/law enforcement and/or case management records for the purpose of referral, intake, assessment, case planning, implementation, and service coordination. Please check the specific type of information/records authorized for release:	
<input type="checkbox"/> School Records/Reports (incl. Special Ed. Reports)	<input type="checkbox"/> Staff Progress Notes
<input type="checkbox"/> Law Enforcement Records/Reports	<input type="checkbox"/> Case Review/Progress Reports
<input type="checkbox"/> Court Reports/Custody Studies	<input type="checkbox"/> Discharge and Closing Summaries
<input type="checkbox"/> Psychiatric Evaluations (incl. dx/prog.)	<input type="checkbox"/> Aftercare Plans
<input type="checkbox"/> Psychological Evaluations (incl. dx/prog.)	<input type="checkbox"/> Medical Reports/Physical Exams (incl. dx/prog.)
<input type="checkbox"/> Admission Histories and Evaluations/Assessments	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Prescriptions for Treatment	<input type="checkbox"/> Speech Therapy Reports
<input type="checkbox"/> Social Histories/Assessments	<input type="checkbox"/> Occupational Therapy Reports
<input type="checkbox"/> Chemical Use/Abuse Histories/Assessments	<input type="checkbox"/> Physical Therapy Reports
<input type="checkbox"/> Treatment Plans/Service Agreements	<input type="checkbox"/> Other (Specify):
IV. Understanding of Consent: This authorization for consent to disclose and release will be effective for information and records generated to the date of signature and the release of information and records created after the date of signature until the expiration date or the release is revoked by me in writing. This authorization for release will also allow for the transfer of and exchange of information that is kept electronically in computer files that will be utilized at CFS team meetings. I also understand that I may revoke this authorization for consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this authorization for consent expires within one year or specified date _____. This authorization for consent will last no longer than reasonably necessary to service the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization. This authorization for disclosure of information and records has been fully explained to me and I understand it. I have been offered a copy of this form. A copy of this authorization for consent has the same force and effect as the original.	
V. Signatures of Authorization:	Date:
Client/Student:	
Parent(s):	
Legal Guardian(s):	
Witness:	

